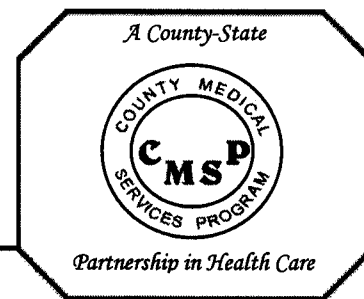


COUNTY MEDICAL SERVICES PROGRAM
MS 5202
P.O. BOX 997413
SACRAMENTO, CA 95899-7413
(916) 552-8015 Fax No.: (916) 552-8018



CMSP Letter No.: 04-12
Issue Date : November 12, 2004

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: COUNTY MEDICAL SERVICES PROGRAM (CMSP)
REDUCED ELIGIBILITY CERTIFICATION (REC) AND
ELIMINATION OF HUNT V. KIZER PROVISIONS

REFERENCE: CMSP ALL COUNTY LETTER (ACL) 04-07, 04-08, 04-09 and 04-11

The ACLs referenced above provide information relating to upcoming changes in the CMSP eligibility process. This letter transmits important additional information relating to these changes and a policy change regarding Hunt v. Kizer, as follows:

1. Provider Letter. Enclosed is a copy of a letter sent to providers describing the upcoming eligibility changes. The letter went to providers in the 34 CMSP counties, plus Fresno, Placer, Sacramento, San Francisco, San Joaquin, Stanislaus, and Yolo counties. This copy is being sent to you for your information.
2. Forms. In prior ACLs, you were sent several updated forms. At this time we are sending the bulk of the remaining forms that have been updated reflecting REC policy changes. Please see the enclosed table that depicts the status of CMSP forms, effective December 1, 2004. Please use the enclosed camera-ready copies as masters to reproduce an adequate supply for your county's use. Other forms that reflect changes, not included in this mailing, will be sent to you soon.
3. Earlier this year, the CMSP Governing Board voted to eliminate the provisions of Hunt v. Kizer from CMSP eligibility policy. The provisions of the lawsuit allow for beneficiaries to deduct from their Share of Cost (SOC) payments they make on a prior health care debt. The Board eliminated the provisions for the following reasons: 1) the deduction, in effect, allows for retroactive payment for services by reducing a current SOC using the amount of old, unpaid medical bills, even

CMSP Welfare Directors
Page 2
November 12, 2004

though CMSP eliminated retroactive eligibility on January 1, 2003, and 2) CMSP is not required to follow its provisions. Notification of this policy change is included because it is reflected in the revision of CMSP Form 219 (one of the revised forms being sent to you with this ACL).

If you have any questions regarding this letter, please contact Ms. Sharon Skinkle at (916) 552-8049.

Sincerely,



Marylyn Willis, Chief
County Medical Services Program Unit

Enclosures

cc: Mr. Lee Kemper
Administrative Officer
CMSP Governing Board
1451 River Park Drive, Suite 222
Sacramento, CA 95815

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
COUNTY MEDICAL SERVICES PROGRAM
MS 5202
P.O. BOX 997413
SACRAMENTO, CA 95899-7413



DATE: November 2, 2004

TO: COUNTY MEDICAL SERVICES PROGRAM (CMSP) PROVIDERS

SUBJECT: UPCOMING ELIGIBILITY CHANGES TO CMSP

The purpose of this letter is to inform you of important eligibility changes to the CMSP. These changes were approved by the CMSP Governing Board on March 25, 2004, and are designed to reduce program administrative costs, which is necessary for the fiscal management of CMSP. We are sending you this notice to assist you in addressing your CMSP patients' eligibility issues. A brief description of these changes is as follows:

1. Elimination of Eligibility for Individuals with Net Non-Exempt Incomes Greater Than 200 percent of the Federal Poverty Level (FPL)

Currently, there is no income limit on CMSP eligibility; however, individuals with net non-exempt incomes above a specified maintenance need level may be eligible for CMSP with a monthly share-of-cost (SOC).

This change will restrict eligibility for CMSP to individuals who have net non-exempt incomes that are equal to, or less than, 200 percent of the FPL. Individuals with net non-exempt incomes over 200 percent of the FPL will no longer be eligible for any CMSP benefits.

2. Time-limited Certification Periods for CMSP Eligibility

Currently, individuals who apply for CMSP are determined eligible with prescribed reporting requirements to maintain their eligibility.

This change will limit CMSP eligibility to a specified time period based upon the CMSP aid code. CMSP beneficiaries will be required to reapply in order to continue eligibility beyond each certification period. Therefore, it is very important that providers verify eligibility for their CMSP patients at the time of service.

As a part of the change to time-limited certification periods, status reports, annual redeterminations, and the requirement that CMSP beneficiaries report changes in their income and resources will be eliminated.

Certification time-limits will be based on the client's aid code:

- Clients who are eligible for full scope CMSP benefits without a monthly SOC (aid codes 84 and 88) will be eligible/certified for six months;
- Clients who are eligible for full scope CMSP benefits with a monthly SOC (aid codes 85 and 89) will be eligible/certified for three months;
- Clients who are eligible for emergency services only, with or without a SOC (aid code 50), will be eligible/certified for the month in which the application is made and the month immediately following;
- Clients who are eligible for CMSP through a companion code (aid code 8F) to Medi-Cal long-term care (aid code 53) will not be affected by this change to time-limited certification periods. However, they will be subject to the income limits as described in No. 1, above.
- It is very important that providers verify eligibility each time they provide services for a CMSP client. This is because a client may have different levels of eligibility, such as SOC, no SOC or no eligibility, in any month during a certification period.

For new applicants, the changes will take effect on December 1, 2004. At that time, current beneficiaries will be evaluated according to this new criteria and either discontinued by the end of December or provided a notice of a certification end date. Beneficiaries who have a continuing need for health care may reapply for benefits.

This information has been provided to CMSP applicants and continuing beneficiaries. Additionally, all CMSP county welfare departments have been informed and are working to implement these changes in their counties. Please note that these changes apply only to CMSP applicants and beneficiaries of the 34 member counties. It does not apply to the Medi-Cal Program or beneficiaries of any other county medically indigent adult program.

If you have any questions regarding this notice, please contact the CMSP office at (916) 552-8015 or your local CMSP county department of social services.

Sincerely,



Marylyn Willis, Chief
County Medical Services Program Unit

County Medical Services Program (CMSP) Forms Effective December 1, 2004
Reduced Eligibility Certification (REC) Policy Changes
Status as of November 12, 2004

Number	Rev. Date	Title	Usage notes	Language	Status
1A	Dec. 2004	Change to Limited Length of Eligibility (Conversion NOA)	One time only usage for converting cases to certification limits and income test policy effective 12/04	Eng/Sp	English and Spanish sent in ACL 04-12
1A (FPL)	Dec. 2004	Change to Limited Length of Eligibility (Conversion NOA)	One time only usage for converting cases to certification limits and income test policy effective 12/04	Eng/Sp	English and Spanish sent in ACL 04-12
Info Notice 1	Dec. 2004	Important Information About the CMSP		Eng only	English sent in ACL 04-12
Info Notice 2	Dec. 2004	Summary CMSP Eligibility		Eng only	Sent in ACL 04-12
210	Dec. 2004	Application for CMSP	new CMSP application	Eng/Sp	Sent in ACLs 04-09 and 04-11
219	Dec. 2004	Rights, Responsibilities & Other Info	revisions include elimination to Hunt v Kizer policy	Eng/Sp	English and Spanish sent in ACL 04-12
237	Dec. 2004	Caseload Movement & Activity Report		Eng only	Sent in ACL 04-12
239 A	Dec. 2004	Denial/Discontinuance of Benefits		Eng/Sp	English and Spanish sent in ACL 04-12
239 B	Dec. 2004	Approval/Denial of Benefits		Eng/Sp	English sent in ACL 04-12
239 F-A	Dec. 2004	Approval of Companion Benefits to Long Term Care	new form	Eng/Sp	Currently under development by CMSP staff
239 F-D	Dec. 2004	Discontinuance of Companion Benefits to Long Term Care	new form	Eng/Sp	Currently under development by CMSP staff
239 P	Dec. 2004	Approval/Denial of Benefits Restricted to Emergency Medical Services		Eng/Sp	English sent in ACL 04-12
1153	Sep. 2004	CMSP Medical Linkage Evaluation	yes	Eng/Sp	Sent in ACL 04-09
NA 9	Dec. 2004	NOA Back	language specific to individual county	Eng/Sp	Counties generate their own form.
	Dec. 2004	Eligibility Brochure	yes	Eng/Sp	Changes underway by CMSP staff
	Dec. 2004	Provider Information Brochure	yes	Eng only	Changes underway by CMSP staff

Forms Unchanged by REC Policy:

239 E	Mar. 1999	Overpayment and Repayment Inst.			
239 R	Aug. 2003	Discontinuance Notice - Deceased Persons			
239 U	Aug. 2003	Utilization of Property			
239 V	Aug. 2002	Utilization of Business Property			
609	Aug. 2002	Co. Request for CMSP Claims Detail			
610	Dec. 2003	Claims Transmittal/Case Resolution			
611	Dec. 2003	CMSP Overpayment Check Handling			
1054	Jul. 2002	SOC Provider Letter			
1175	Aug. 2003	Medical Care Hearing Request			
1176	Apr. 1999	Potential Third Party Liability Notification			
1178	Jul. 2002	Profit and Loss Statement			
1179	Dec. 2003	Eligibility Expenditure Report by FY			
		Request for CMSP Data and Other Information/Assistance			
1180	Feb. 2004				

Forms Discontinued/Obsoleted by REC Effective 12/1/04:

176 SQ	Aug. 2003	Quarterly Status Report			
177 P	Sep. 2003	Record of Healthcare Cost Spenddown			
239 C	Jul. 2002	Change in SOC			
239 G	Aug. 2003	Spenddown of Property			
239 I	Jul. 2002	Discon of Benefits Status Report Not Received or Not Completed			
239 Q	Jul. 2002	Change From Restricted Svcs to Full Benefits			

**COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
CHANGE TO LIMITED LENGTH OF ELIGIBILITY**

Case name: _____
Case number: _____
District: _____
This affects: _____
(Name)

This notification is to inform you of changes to your County Medical Services Program (CMSP) eligibility. Effective January 1, 2005, CMSP rules have changed. The number of months you can get CMSP is limited and your income cannot exceed 200% of the Federal Poverty Level. Your benefits have been converted to these new rules.

Your current eligibility period will end the last day of _____.
(month/year)

Your share of cost for this period is: \$_____per month.

You will be automatically discontinued from CMSP at the end of the month stated above. If you continue to need aid after the date of discontinuance, you can reapply beginning in your last month of eligibility. Please do not reapply sooner.

Do not throw your plastic ID card away. You can use it again if you become eligible for CMSP or Medi-Cal. The authority that requires this action is in CMSP All County Letter No. 04-07 and/or appropriate CMSP Eligibility Manual sections.

Eligibility Worker

Phone

Date

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

PROGRAMMA DE SERVICIOS MEDICOS DEL CONDADO (CMSP)
NOTIFICACIÓN DE ACCIÓN
Cambio al Tiempo Limitado de Elegibilidad

Nombre del Caso: _____
Numero del Caso: _____
Distrito: _____
Esto Afecta: _____
(Nombre)

Esta notificación es para informarle de los cambios a su elegibilidad del Programa de Servicios Médicos del Condado (CMSP). Comenzando el 1 de enero de 2005, las reglas de CMSP han cambiado. El número de los meses que alguien se permite permanecer en CMSP es limitado y sus ingresos no pueden exceder la cantidad permitida debajo del Programa de 200 por ciento del Nivel de Pobreza Federal. Sus beneficios se han convertido a estas reglas nuevas.

Su elegibilidad actual se terminará el último día de _____.
(mes/ año)

Su parte del costo por este período es: \$ _____ por mes.

Automáticamente usted sera descontinuado del CMSP al fin del mes indicado arriba. Si usted continúa necesitando la ayuda después de la fecha de la discontinuación, usted puede aplicar de nuevo empezando en el último mes de su elegibilidad. Por favor no reaplique antes del último mes.

No tire su tarjeta de identificación de CMSP. Usted puede utilizarla otra vez si usted es elegible de nuevo para CMSP o Medi-Cal. La autoridad que requiere esta acción esta en la carta "CMSP All County Letter No. 04-07" o en las secciones apropiadas del Manual de la Elegibilidad de CMSP.

Nombre del/de Trabajador(a)
de Elegibilidad

Telefono

Fecha

Por favor lea el reverso de este aviso.

**COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
CHANGE TO LIMITED LENGTH OF ELIGIBILITY**

Case name: _____
Case number: _____
District: _____
This affects: _____
(Name)

This notification is to inform you of changes to your County Medical Services Program (CMSP) eligibility. Effective January 1, 2005, CMSP rules have changed. The number of months you can get CMSP is limited and your income cannot exceed 200% of the Federal Poverty Level. Your benefits have been converted to these new rules.

Your current eligibility period will end the last day of _____.
(month/year)

Your income exceeds 200% of the Federal Poverty Level.

You will be automatically discontinued from CMSP at the end of the month stated above. If you continue to need aid after the date of discontinuance, you can reapply beginning in your last month of eligibility. Please do not reapply sooner.

Do not throw your plastic ID card away. You can use it again if you become eligible for CMSP or Medi-Cal. The authority that requires this action is in CMSP All County Letter No. 04-07 and/or appropriate CMSP Eligibility Manual sections.

Eligibility Worker

Phone

Date

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

PROGRAMMA DE SERVICIOS MEDICOS DEL CONDADO (CMSP)
NOTIFICACIÓN DE ACCIÓN
Cambio al Tiempo Limitado de Elegibilidad

Nombre del Caso: _____
Número del Caso: _____
Distrito: _____
Esto Afecta: _____
(Nombres)

Esta notificación es para informarle de los cambios a su elegibilidad del Programa de Servicios Médicos del Condado (CMSP). Comenzando el 1 de enero de 2005, las reglas de CMSP han cambiado. El número de los meses que alguien se permite permanecer en CMSP es limitado y sus ingresos no pueden exceder la cantidad permitida debajo del Programa de 200 por ciento del Nivel de Pobreza Federal. Sus beneficios se han convertido a estas reglas nuevas.

Su elegibilidad actual se terminará el último día de _____.
(mes/año)

Sus ingresos exceden la cantidad permitida debajo del Programa de 200 por ciento del Nivel de Pobreza Federal.

Automáticamente usted sera descontinuado del CMSP al fin del mes indicado arriba. Si usted continúa necesitando la ayuda después de la fecha de la discontinuación, usted puede aplicar de nuevo empezando en el último mes de su elegibilidad. Por favor no reaplique antes del último mes.

No tire su tarjeta de identificación de CMSP. Usted puede utilizarla otra vez si usted es elegible de nuevo para CMSP o Medi-Cal. La autoridad que requiere esta acción esta en la carta "CMSP All County Letter No. 04-07" o en las secciones apropiadas del Manual de la Elegibilidad de CMSP.

Nombre del/de Trabajador(a)
de Elegibilidad

Teléfono

Fecha

Por favor lea el reverso de este aviso.

IMPORTANT INFORMATION ABOUT THE COUNTY MEDICAL SERVICES PROGRAM (CMSP)

PLEASE UNDERSTAND THAT CMSP IS NOT THE MEDI-CAL PROGRAM.

When eligible for CMSP, you will receive a plastic State of California Benefits Identification Card (BIC) and a MedImpact (MI) card. Please see the backside of this notice for instructions on when to use these cards. The length of time you will be eligible to receive CMSP benefits is limited. You will be notified of this limited certification period.

MISUSE OF YOUR BIC OR MI CARDS COULD RESULT IN A REDUCTION OF YOUR BENEFITS, TERMINATION OF YOUR ELIGIBILITY, AND/OR PROSECUTION (TITLE 22, CCR, SECTION 50733(d)).

BENEFITS. You should always carry your cards with you. Your cards may be used *only by you* to receive the following care:

- Acute inpatient hospital care (including acute inpatient rehabilitation)
- Adult day health care services
- Audiology services
- Blood and blood derivatives
- Chronic hemodialysis services
- Dental services
- Durable medical equipment
- Emergency air and ground ambulance services
- Hearing aids
- Home health agency services
- Hospital outpatient services
- Laboratory and radiology services
- Medical supplies, when prescribed by a licensed practitioner within the scope of his/her practice, or durable medical equipment dealers, and prosthetic and orthotic providers
- Nonemergency medical transportation
- Occupational therapy services
- Optometry services (see excluded benefits below)
- Outpatient clinic services
- Outpatient heroin detoxification services
- Pharmaceutical services provided by network pharmacists (ask your county department for a list of network pharmacies)
- Physical therapy services
- Physicians' services
- Podiatry services
- Prosthetic and orthotic appliances
- Rehabilitation clinics
- Speech therapy services

EXCLUDED BENEFITS. CMSP *does not include* the following services:

- Eye appliances including frames, lenses, contact lenses, low-vision aids, and prosthetic eyes.
- Pregnancy-related services (contact your county eligibility office)
- Long-term care facility services (contact your county eligibility office)
- Services of chiropractors, acupuncturists, psychologists, licensed clinical social workers, or marriage and family therapists

If you need or desire medical care which is not covered by CMSP, you must pay for it yourself or make other arrangements with the provider. Check with your county health department for possible health care resources available in your county.

See the backside of this notice for additional Important Information.

ENFORCEMENT OF CMSP AS A SECONDARY PAYER. CMSP is the "provider of last resort." If you are infected with HIV or AIDS, are seeking family planning services, or have Hepatitis C, you may be eligible for services through other state programs. The other state programs are:

1. California AIDS Drug Assistance Program (ADAP)—for information, call (916) 445-0553.
2. Family Planning, Access, Care, and Treatment Program (Family PACT)—for information, call (800) 942-1054.
3. Hepatitis C—Drug Company Patient Assistance Programs (PAPs)—information is available on the internet at: www.helpingpatients.org. Your medical provider may also be able to provide information.

You must use these programs before receiving services from CMSP. If you need prescriptions, your physician or pharmacy will need to provide documentation that you were not able to obtain services from the above mentioned programs. *Without this proof, medications related to medical conditions covered by the above programs will be denied.* Information on the prior approval process can be found at www.cmspcounties.org.

USING YOUR CARD. *You should always carry your BIC and MI cards with you.* Your providers will use the plastic BIC card to identify you and process your share-of-cost (SOC), if any. Additionally, your pharmacy will use the MI card to bill CMSP for prescriptions. In an emergency, obtain medical care immediately, even if you do not have your cards with you. Remember, however, to tell the provider that you are covered by CMSP and show the provider your card(s) as soon as possible after you have received care.

PRIOR AUTHORIZATIONS. There may be some limitations on the amount of care you may receive with your cards. Also, many services may require prior approval by CMSP consultants before they are given. Your doctor or other provider should know the limitations, and is responsible to request any necessary approval from the California Department of Health Services. (Note: Local Medi-Cal field offices approve treatment requests for CMSP medical services, dental service requests are processed by Denti-Cal, and pharmacy service requests are processed by MI.)

COPAYMENTS. You may be required to pay \$1 for medication prescriptions, \$1 for office visits, and \$5 for emergency room visits which are not emergencies.

SHARE-OF-COST. Some persons eligible for CMSP have a SOC obligation. If you have a SOC, you must pay, or agree to pay, part of your monthly income toward your medical expenses before CMSP will pay for covered benefits. Your county worker will explain how this works.

CERTIFICATION PERIODS. Depending on what CMSP eligibility category you are in, your time on CMSP (certification period) will be different. Clients who are eligible for emergency services only will be certified for two months. Clients with a SOC will be certified for three months and clients without a SOC will be certified for six months. If you have a need to continue services beyond your certification period, you will need to apply for benefits again.

FINDING A PROVIDER. *Remember:* the person or facility providing care **does not** have to accept the BIC or MI cards. Find out if the provider accepts the card **before** you go for treatment or services. It is your responsibility to show the provider your cards at the time you receive services. CMSP payments to your provider are considered payment in full for the services which you receive, although these payments may be less than a provider's usual and customary charges. Aside from your possible SOC, you are not obligated to pay any difference between the provider's charges and CMSP's rate of payment.

BILLING THE PROGRAM. Only Medi-Cal or MI providers of services are eligible to bill CMSP. If your provider does not accept CMSP and you decide to pay for the services in order to continue seeing that provider, CMSP cannot reimburse you for those services.

OTHER HEALTH COVERAGE. You are required to notify your county eligibility office if you are covered by any health insurance carrier. Other health coverage (OHC) information will be identified on your CMSP eligibility record, and providers of service must bill the OHC prior to billing CMSP.

THIRD PARTY LIABILITY. You are required to report to your county eligibility office when CMSP will be billed for health care services you received as a result of an accident or injury caused by some other person's action or failure to act.

FAIR HEARING. If you are dissatisfied with any decisions regarding medical care under the CMSP, you have the right to request a hearing by the Department of Social Services. You should either request a copy of the Medical Care Hearing Request, form CMSP 1175, from your eligibility worker or telephone the Public Inquiry and Response Unit at 1-800-952-5253. The completed form CMSP 1175 should be mailed to the address listed on the form.

SUMMARY CMSP ELIGIBILITY

Description of Eligible Person	Medically indigent adult who meets all CMSP eligibility criteria and is not eligible for Medi-Cal.																									
Age Limits	21 through 64 years of age.																									
Residence and Citizenship	California residence. Residence in a CMSP county. Full Benefits: A citizen of the United States or an alien who is: lawfully admitted for permanent residence; permanently residing in the United States under color of law. Emergency Services Only: Persons whose immigration status has not been determined.																									
Personal Property Limits	<table><thead><tr><th>Number of Persons Whose Property Is Considered</th><th>Property Limit</th></tr></thead><tbody><tr><td>1 person.....</td><td>\$2,000</td></tr><tr><td>2 persons.....</td><td>3,000</td></tr><tr><td>3 persons.....</td><td>3,150</td></tr><tr><td>4 persons.....</td><td>3,300</td></tr><tr><td>5 persons.....</td><td>3,450</td></tr><tr><td>6 persons.....</td><td>3,600</td></tr><tr><td>7 persons.....</td><td>3,750</td></tr><tr><td>8 persons.....</td><td>3,900</td></tr><tr><td>9 persons.....</td><td>4,050</td></tr><tr><td>10 or more persons</td><td>4,200</td></tr></tbody></table> Spenddown of excess property permitted.	Number of Persons Whose Property Is Considered	Property Limit	1 person.....	\$2,000	2 persons.....	3,000	3 persons.....	3,150	4 persons.....	3,300	5 persons.....	3,450	6 persons.....	3,600	7 persons.....	3,750	8 persons.....	3,900	9 persons.....	4,050	10 or more persons	4,200			
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7 persons.....	3,750																									
8 persons.....	3,900																									
9 persons.....	4,050																									
10 or more persons	4,200																									
Motor Vehicle Limits	One vehicle exempt—no maximum value.																									
Real Property Limits	Principal residence, including any appertaining buildings and land used as a home is exempt if the applicant/beneficiary lives there. Other real property with a net market value of \$6,000 or less is exempt if utilization requirements are met.																									
Income Limits	Less than or equal to 200% of the Federal Poverty Level (based on the net nonexempt income).																									
Relative Responsibility	Spouse for spouse. Parent for ineligible child living in parent's home.																									
Need Standard	<table><thead><tr><th></th><th>CMSP Monthly Maintenance Need</th></tr></thead><tbody><tr><td>1 person.....</td><td>\$ 600</td></tr><tr><td>2 persons.....</td><td>750</td></tr><tr><td>2 adults.....</td><td>934</td></tr><tr><td>3 persons.....</td><td>934</td></tr><tr><td>4 persons.....</td><td>1,100</td></tr><tr><td>5 persons.....</td><td>1,259</td></tr><tr><td>6 persons.....</td><td>1,417</td></tr><tr><td>7 persons.....</td><td>1,550</td></tr><tr><td>8 persons.....</td><td>1,692</td></tr><tr><td>9 persons.....</td><td>1,825</td></tr><tr><td>10 or more persons</td><td>1,959</td></tr></tbody></table> Each additional person, add \$14.		CMSP Monthly Maintenance Need	1 person.....	\$ 600	2 persons.....	750	2 adults.....	934	3 persons.....	934	4 persons.....	1,100	5 persons.....	1,259	6 persons.....	1,417	7 persons.....	1,550	8 persons.....	1,692	9 persons.....	1,825	10 or more persons	1,959	
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8 persons.....	1,692																									
9 persons.....	1,825																									
10 or more persons	1,959																									
Share-of-Cost (SOC)	Net nonexempt income minus maintenance need equals share-of-cost. Share-of-cost must be paid or obligated before certification for program benefits.																									
Certification Period Limits	2 months—emergency services only 3 months—share-of-cost 6 months—no share-of-cost Clients wishing to continue their eligibility beyond the certification period may reapply.																									
Provider Network	All approved Medi-Cal and MediImpact providers—not limited to providers in CMSP counties.																									

Please note that this is a general summary. For exceptions and details, consult your county welfare department.

COUNTY MEDICAL SERVICES PROGRAM (CMSP) RIGHTS, RESPONSIBILITIES, AND OTHER INFORMATION

Print name of applicant	Date
Print name of person acting for applicant	Relationship to applicant

Be sure you have read every item, and sign and date. Read the following carefully before signing.

- I understand that I am applying for the County Medical Services Program and that I am *not* applying for the state Medi-Cal Program.
- I understand that I have declared citizenship or immigration status on the CMSP 210, MC 13, MC 210, SAWS 2, or other Medi-Cal form. I understand that my declaration of citizenship or immigration status for Medi-Cal eligibility will also be used in determining CMSP eligibility.

CMSP RIGHTS, RESPONSIBILITIES, AND OTHER INFORMATION

You have the right to:

- Ask for an interpreter to help you in applying for CMSP benefits if you have difficulty in speaking or understanding the English language.
- Be treated fairly and equally regardless of your race, color, religion, national origin, sex, age, or political beliefs.
- Apply for CMSP benefits and to be told in writing whether or not you qualify for CMSP, even if the county representative tells you during the interview that it appears that you are, or are not now, eligible.
- Review manuals containing the rules of the CMSP if you want to question the basis on which your eligibility is approved or denied.
- Receive a Benefits Identification Card (BIC) as soon as possible if you have a medical emergency.
- Have all information you give to the county department kept in the strictest confidence.
- Qualify for the CMSP by reducing your property reserve to within the CMSP property limit by the last day of any month, including the month of application.
- Receive an explanation of possible ways that you may spend your excess property as long as you receive adequate consideration.
- Speak to a social service worker about other public or private services or resources that may be available to you.
- Request a hearing from the county if you are dissatisfied with an action taken, or not taken, by the county Department of Social Services. If you wish such a hearing, you must request one within 30 days of the date the Notice of Action was mailed to you. If you do not receive a Notice of Action, you must request the hearing within 30 days of the date that you became aware of the action of which you are dissatisfied.

You have the responsibility to:

- Present when requested verification that you are a resident of the county in which you are applying for CMSP.
- Tell your medical provider (doctor, dentist, etc.) that you have applied for CMSP or are a CMSP beneficiary.
- Sign and keep your BIC and use it only to obtain necessary health care.
- Take your BIC to your medical provider when you receive medical care, as soon as possible if you receive services and do not have your BIC with you.
- Provide a social security number to the county or apply for one.
- Apply for Medicare benefits if you are blind, disabled, or aged 64 years and 9 months or older and are eligible for these benefits.
- Apply for any income which may be available to you or your family members.
- Report to the county department any health care insurance that you have or are entitled to have.
- Use any health insurance which you have before using the CMSP.
- Report to the county department when CMSP benefits received are a result of an accident or injury caused by some other person's action or failure to act.
- Cooperate with the county if your case is selected for a quality control review.
- Cooperate with Medi-Cal regulations if you are potentially eligible for Medi-Cal (this includes the disability evaluation process). If you do not cooperate and you are found ineligible for Medi-Cal, you will not be eligible for CMSP benefits.

YOU HAVE THE RESPONSIBILITY TO NOTIFY YOUR COUNTY ELIGIBILITY WORKER WITHIN TEN DAYS WHENEVER:

- You move or plan to move to another address in your county, to another county, or to another state or country.
- You plan to be away from your home (residence) for more than 60 days.
- Any person moves into or out of your home.
- You or your spouse enters or leaves a nursing home or long-term care facility.

- You or a family member becomes pregnant or the pregnancy ends.
- You or a family member applies for any disability benefits, such as SSI/SSP, Social Security, Railroad Retirement, Veterans Benefits, Workers' Compensation, etc.
- You or a family member has a change in health insurance, citizenship, or immigration status.

I UNDERSTAND THAT:

- When I apply for CMSP benefits I will be evaluated for eligibility for other programs including Medi-Cal.
- If I obtain medical services from a medical provider who is not a CMSP provider, I will be responsible for the cost of the services I receive.
- Based on my income, I may have to pay, or be billed for, some of my own medical expenses each month before the CMSP will begin to pay.
- If I give false or incomplete information, I may be found ineligible for the CMSP and I may be investigated for suspected fraud.
- The facts I give may be checked by computer with information from employers, the Franchise Tax Board, Social Security Administration, banks, welfare, and other agencies.
- If I, or a person I am applying for, do not have documentation of satisfactory immigration status, I, or the person I am applying for, may be eligible only for emergency CMSP services.
- If I do not report changes promptly, and I receive CMSP benefits that I am not eligible for, I may have to repay the CMSP for those benefits.
- If I am eligible for other health insurance at no cost to me and do not apply for it or fail to keep such insurance, my CMSP eligibility may be denied or discontinued.
- If my medical provider accepts my CMSP for covered services, they cannot bill me for those services except for any share-of-cost that I may have.

I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose my CMSP eligibility and/or I can be prosecuted for fraud.

I hereby state that I have read the information on this form and that I fully understand my RIGHTS AND RESPONSIBILITIES to have my eligibility determined for the CMSP and to maintain that eligibility.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of applicant		Phone number ()	Date
Signature of person acting for applicant	Relationship to applicant	Phone number ()	Date
Signature of witness (If applicant signed with mark)		Phone number ()	Date

I have provided to the applicant (*check one*) ☐ in person ☐ by mail the rights, responsibilities, and other information listed on this form.

Signature of Eligibility Worker (EW) (if applicable)	EW number (if applicable)	Phone number ()	Date
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Privacy and Confidentiality Notification

Sections 14011 and 14012 of the Welfare and Institutions Code authorize county social service/welfare departments to collect certain information from you to determine if you or the person(s) you are applying for are eligible for CMSP benefits. The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer the CMSP. This information will be used by the county department to establish initial and ongoing CMSP eligibility; by the State's fiscal intermediary for claims processing purposes; by the California Department of Health Services for BIC production, health insurance identifications, and overpayment recovery actions; for Medicare Buy-In and social security number verification; by the Immigration and Naturalization Service to determine alien status; and by medical providers of services and health maintenance organizations for eligibility verification.

Providing this information is mandatory. Failure to do so will result in your ineligibility for CMSP benefits. You have the right to look at your information and may do so at the county department during regularly scheduled office hours.

DERECHOS, RESPONSABILIDADES Y OTRA INFORMACIÓN DEL PROGRAMA DE SERVICIOS MÉDICOS DEL CONDADO (CMSP)

Escriba el nombre del/de la solicitante en letra de molde	Fecha
Escriba el nombre de la persona que actúa en nombre del/de la solicitante en letra de molde	Parentesco con el/la solicitante

Asegúrese de haber leído cada cosa, y firme y ponga la fecha. Lea lo siguiente detenidamente, antes de firmar.

- Entiendo que estoy solicitando beneficios del Programa de Servicios Médicos del Condado (County Medical Services Program—CMSP), y que no estoy solicitando beneficios del Programa de Medi-Cal del estado.
- Entiendo que he declarado mi ciudadanía o mi situación migratoria en las formas CMSP 210, MC 13, MC 210, SAWS 2, o otra forma del Medi-Cal. Entiendo que mi declaración de ciudadanía o situación migratoria para la elegibilidad de Medi-Cal también será utilizada en la determinación de elegibilidad para el CMSP.

DERECHOS, RESPONSABILIDADES Y OTRA INFORMACIÓN SOBRE EL CMSP

Usted tiene derecho a:

- Pedir que un(a) intérprete le ayude a solicitar los beneficios del CMSP, si usted tiene dificultades para hablar o entender el idioma inglés.
- Que se le trate justa y equitativamente independientemente de su raza, color, religión, origen nacional, sexo, edad o creencias políticas.
- Solicitar beneficios del CMSP, y a que se le informe, por escrito, si usted reúne los requisitos o no para el CMSP, aun si el/la representante del condado le informa a usted durante la entrevista que parece ser que si reúne los requisitos o que no los reúne ahora.
- Revisar los manuales que contengan las reglas del CMSP, si usted desea cuestionar el fundamento bajo el cual se aprobó o negó su elegibilidad.
- Recibir una Tarjeta de Identificación de Beneficios (Benefits Identification Card—BIC) lo antes posible, si tiene una emergencia médica.
- Que toda la información que usted proporcione al departamento del condado se mantenga en la confidencialidad más estricta.
- Reunir los requisitos para el CMSP, al reducir su reserva de bienes para que esté dentro del límite de bienes del CMSP, a más tardar el último día de cualquier mes, incluyendo el mes de su solicitud.
- Recibir una explicación sobre las posibles maneras en que usted puede gastar su exceso de bienes, siempre y cuando usted reciba consideración adecuada.
- Hablar con un(a) trabajador(a) de servicios sociales sobre otros servicios o recursos públicos o privados que podrían estar a su disposición.
- Solicitar una audiencia del condado, si usted está insatisfecho(a) con una acción que el Departamento de Servicios Sociales del condado haya tomado o no. Si usted desea una audiencia tal, tiene que solicitarla en un plazo de 30 días, a partir de la fecha en que se le envió la Notificación de Acción. Si usted no recibe una Notificación de Acción, usted tiene que solicitar la audiencia en un plazo de 30 días, a partir de la fecha en que usted se dio cuenta de la acción con la que usted está insatisfecho(a).

Usted tiene la responsabilidad de:

- Presentar, cuando se le pida, comprobante de que usted es residente del condado en el que esté solicitando beneficios del CMSP.
- Informarle a su proveedor médico [doctor(a), dentista, etc.] que usted ha solicitado beneficios del CMSP, o que es beneficiario(a) del CMSP.
- Firmar y guardar su BIC, y usarla solamente para obtener atención médica necesaria.
- Llevar su BIC a su proveedor médico cuando usted reciba atención médica, lo antes posible, si usted recibe servicios y no tiene su BIC consigo.
- Proporcionar un número de seguro social al condado, o solicitar uno.
- Solicitar beneficios de Medicare, si usted está ciego(a), incapacitado(a) o tiene 64 años y 9 meses de edad o más, y reúne los requisitos para estos beneficios.
- Solicitar para cualquier ingreso que podría estar a su disposición o a la de sus familiares.
- Reportar al departamento del condado cualquier seguro de atención médica que usted tenga o al que tenga derecho.
- Usar cualquier seguro médico que usted tenga, antes de usar el CMSP.
- Reportar al departamento del condado cuando los beneficios del CMSP recibidos son el resultado de un accidente o lesión causado por la acción de alguna otra persona, o por que no actuó.
- Cooperar con el condado, si su caso se selecciona para una evaluación de control de calidad.
- Cooperar con los ordenamientos de Medi-Cal, si posiblemente usted reúna los requisitos para recibir Medi-Cal (esto incluye el proceso de evaluación de incapacidad). Si usted no coopera, y se determina que no reúne los requisitos para recibir Medi-Cal, usted no reunirá los requisitos para recibir beneficios del CMSP.

USTED TIENE LA RESPONSABILIDAD DE NOTIFICAR A SU TRABAJADOR(A) DE ELEGIBILIDAD DEL CONDADO, EN UN PLAZO DE DIEZ DÍAS, CUANDO:

- Usted se mude o planea mudarse a otra dirección en su condado, a otro condado o a otro estado o país.
- Usted planea ausentarse de su hogar (residencia) durante más de 60 días.
- Alguna persona se mude a o fuera de su hogar.
- Usted o su cónyuge ingrese o salga de un centro de convalecencia o establecimiento de atención a largo plazo.
- Usted o una pariente resulte embarazada o el embarazo se termine.
- Usted o un(a) pariente solicite algún beneficio por incapacidad, como SSI/SSP, seguro social, Jubilación de Ferrocarriles, Beneficios para Veteranos, Compensación para los Trabajadores, etc.
- Usted o un(a) pariente tenga un cambio en seguro médico, ciudadanía o situación migratoria.

ENTIENDO QUE:

- Cuando solicite beneficios del CMSP, se me hará una evaluación para determinar mi elegibilidad para otros programas, incluyendo Medi-Cal.
- Si obtengo servicios médicos de un proveedor médico que no sea un proveedor del CMSP, seré responsable del costo de los servicios que reciba.
- En base a mis ingresos, es posible que tenga que pagar, o que se me cobren, algunos de mis propios gastos médicos cada mes, antes de que el CMSP comience a pagar.
- Si doy información falsa o incompleta, es posible que se determine que no reúno los requisitos para el CMSP, y que se me investigue por sospecha de fraude.
- Los datos que se corroborarán por computadora con información de empleadores, el Departamento de Impuestos del Estado, la Administración del Seguro Social, bancos, departamentos de asistencia pública y otras agencias.
- Si yo, o una persona para la que estoy solicitando beneficios, no tenemos documentación o una situación migratoria satisfactoria, yo, o la persona para la que estoy solicitando beneficios, posiblemente reunamos los requisitos solamente para servicios de emergencia del CMSP.
- Si no reporto cambios oportunamente, y recibo beneficios del CMSP para los que no reúno los requisitos, es posible que tenga que pagarle al CMSP tales beneficios.
- Si reúno los requisitos para otro seguro médico, sin costo alguno para mí, y no lo solicito, o no retengo dicho seguro, mi elegibilidad del CMSP posiblemente se me niegue o descontinúe.
- Si mi proveedor médico acepta mi CMSP para los servicios cubiertos, no pueden cobrárme tales servicios, excepto cualquier parte del costo que pudiera tener.

Estoy consciente de que si hago declaraciones falsas o retengo información deliberadamente, yo (o la persona en cuyo nombre estoy actuando) podríamos perder la elegibilidad del CMSP, o podríamos ser procedados por fraude.

Por este medio, declaro que he leído la información en este formulario, y que entiendo plenamente mis DERECHOS Y RESPONSABILIDADES, para que se determine mi elegibilidad para el CMSP, y para mantener esa elegibilidad.

DECLARO, BAJO PENA DE PERJURIO, CONFORME A LAS LEYES DEL ESTADO DE CALIFORNIA, QUE LAS RESPUESTAS QUE HE DADO SON CORRECTAS Y VERDADERAS A MI LEAL SABER Y ENTENDER.

Firma del/de la solicitante		Número de teléfono ()	Fecha
Firma de la persona que actúa en nombre del/de la solicitante	Relación con el/la solicitante	Número de teléfono ()	Fecha
Firma del/de la testigo (si el/la solicitante firmó con una huella)		Número de teléfono ()	Fecha
Le he proporcionado al solicitante (<i>marke uno</i>) <input type="checkbox"/> en persona <input type="checkbox"/> por correo los derechos, las responsabilidades, y la otra información enumerada en esta forma.			
Firma del/de la Trabajador(a) de Elegibilidad (EW) (si es pertinente)	Número del/de la EW (si es pertinente)	Número de teléfono ()	Fecha

Notificación de Privacidad y Confidencialidad

Las Secciones 14011 y 14012 del Código de Instituciones y Asistencia Pública autoriza a los departamentos de servicios sociales y de asistencia pública del condado a que recopile cierta información de usted, para determinar si usted o la(s) persona(s) para la(s) que esté solicitando beneficios reúne(n) los requisitos para beneficios del CMSP. La información que usted proporcione es confidencial, y solamente puede revelárseles a ciertos individuos o organizaciones, y entonces solamente para administrar el CMSP. Esta información la utilizará el departamento del condado para establecer la elegibilidad inicial y continua del CMSP; el intermediario fiscal del Estado para fines de tramitar reclamos; el Departamento de Servicios de Salud para la producción de BICs, identificaciones de seguro médico y medidas para recuperar pagos excesivos e indebidos; para comprobar números de seguro social y números otorgados por Medicare; el Servicio de Inmigración y Naturalización para determinar la situación como extranjeros; y los proveedores de servicios médicos y organizaciones para la conservación de la salud para comprobar la elegibilidad.

El proporcionar esta información es obligatorio. El no hacerlo resultará en su inelegibilidad para beneficios del CMSP. Usted tiene derecho a ver su información, y puede hacerlo en el departamento del condado durante horas hábiles regulares.

INDIVIDUAL MOVEMENT AND ACTIVITY REPORT (County Medical Services Program Only)

Mail or fax one copy to:
 California Department of Health Services
 Office of County Health Services
 MS 5202
 1501 Capitol Avenue, Suite 5195
 P.O. Box 997413
 Sacramento, CA 95899-7413
 Fax number: (916) 552-8018

County

Report month

Intake Activity

	Approvals	Denied (Income)	Denied (Property)	Denied (Other)	Withdrawals	Pending	Total
1. Pending applications on hand at beginning of month	1	2	3	4	5	6	7
2. New applications	8	9	10	11	12	13	14
3. Reapplications (3a + 3b + 3c + 3d)	15	16	17	18	19	20	21
a. Reapplication without break	22	23	24	25	26	27	28
b. Reapplication within two months	29	30	31	32	33	34	35
c. Reapplication within three months	36	37	38	39	40	41	42
d. Reapplication with more than 3 months and less than 1 year	43	44	45	46	47	48	49
4. Total applications on hand during the month (1 + 2 + 3)							50
5. Total applications disposed during the month (5a + 5b + 5c)							51
a. Approvals	52						53
b. Denials (5bi + 5bii + 5biii)							54
i. Over income	55						
ii. Over property	56						
iii. Other	57						
c. Withdrawals	58						59
6. Pending applications carried forward to next month							60
7. Annual redetermination of eligibility for 8F-only clients							61
8. Total disposed and redetermination activity (5 + 7)							62

Continuing Activity

9. Continuing individuals on hand at beginning of month		63
10. Individuals added during month (10a + 10b)		64
a. Individuals added from intake (5a)	65	
b. Other approvals	66	
11. Total continuing individuals during month (9 + 10)		67
12. Total individuals discontinued during month		68
a. End of certification period		69
b. Linked to Medi-Cal		70
i. SSI	71	
ii. DAPD	72	
iii. Other	73	
c. Client requested—wanted to reapply with budget change		74
d. Client requested—other		75
e. Other		76
13. Continuing individuals carried forward to next month (11–12)		77

County person to contact regarding this report

Telephone number

Date prepared

County Medical Services Program Form 237 Cell-by-Cell Description - Final

Cell Number	Description
Cell 1	This cell represents the total number of CMSP applications that were pending at the beginning of the report month and were approved in the report month.
Cell 2	This cell represents the total number of CMSP applications that were pending at the beginning of the report month and were denied in the reporting month due to excess income.
Cell 3	This cell represents the total number of CMSP applications that were pending at the beginning of the report month and were denied in the report month due to excess resources.
Cell 4	This cell represents the total number of CMSP applications that were pending at the beginning of the report month and were denied in the report month due to other reasons.
Cell 5	This cell represents the total number of CMSP applications that were pending at the beginning of the report month and were withdrawn in the report month.
Cell 6	This cell represents the total number of CMSP applications that were pending at the beginning of the report month and were still pending at the end of the report month.
Cell 7	This Cell represents the arithmetic total of Cell 1, Cell 2 ,Cell 3, Cell 4, Cell 5 and Cell 6.
Cell 8	This cell represents the total number of new CMSP applications that were received during the report month and were approved during the report month.
Cell 9	This cell represents the total number of new CMSP applications that were received during the report month and were denied during the report month due to excess income.
Cell 10	This cell represents the total number of new CMSP applications that were received during the report month and were denied during the report month due to excess resources.
Cell 11	This cell represents the total number of new CMSP applications that were received during the report month and were denied during the report month due to other reasons.
Cell 12	This cell represents the total number of new CMSP applications that were received during the report month and were withdrawn during the report month.
Cell 13	This cell represents the total number of new CMSP applications that were received during the report month and were still pending at the end of report month.
Cell 14	This Cell represents the arithmetic total of Cell 8, Cell 9,Cell 10, Cell 11, Cell 12 and Cell 13.
Cell 15	This Cell represents the arithmetic total of Cell 22, Cell 29,Cell 36 and Cell 43.
Cell 16	This Cell represents the arithmetic total of Cell 23, Cell 30,Cell 37 and Cell 44
Cell 17	This Cell represents the arithmetic total of Cell 24, Cell 31,Cell 38 and Cell 45
Cell 18	This Cell represents the arithmetic total of Cell 25, Cell 32,Cell 39 and Cell 46
Cell 19	This Cell represents the arithmetic total of Cell 26, Cell 33,Cell 40 and Cell 47
Cell 20	This Cell represents the arithmetic total of Cell 27, Cell 34,Cell 41 and Cell 48
Cell 21	This Cell represents the arithmetic total of Cell 28, Cell 35,Cell 42 and Cell 49
Cell 22	This cell represents the total number of CMSP re-applications taken without break that were received during the report month and were approved during the report month.
Cell 23	This cell represents the total number of CMSP re-applications taken without break that were received during the report month and were denied during the report month due to excess income.
Cell 24	This cell represents the total number of CMSP re-applications taken without break that were received during the report month and were denied during the

County Medical Services Program Form 237 Cell-by-Cell Description - Final

	report month due to excess resources.
Cell 25	This cell represents the total number of CMSP re-applications taken without break that were received during the report month and were denied during the report month due to other reasons.
Cell 26	This cell represents the total number of CMSP re-applications taken without break that were received during the report month and were withdrawn during the report month.
Cell 27	This cell represents the total number of CMSP re-applications taken without break that were received during the report month and were still pending at the end of the report month.
Cell 28	This Cell represents the arithmetic total of Cell 22, Cell 23, Cell 24, Cell 25, Cell 26 & Cell 27.
Cell 29	This cell represents the total number of CMSP re-applications taken with a 2 month break that were received during the report month and were approved during the report month.
Cell 30	This cell represents the total number of CMSP re-applications taken with a 2 month break that were received during the report month and were denied during the report month due to excess income.
Cell 31	This cell represents the total number of CMSP re-applications taken with a 2 month break that were received during the report month and were denied during the report month due to excess resources.
Cell 32	This cell represents the total number of CMSP re-applications taken with a 2 month break that were received during the report month and were denied during the report month due to other reasons.
Cell 33	This cell represents the total number of CMSP re-applications taken with a 2 month break that were received during the report month and were withdrawn during the report month.
Cell 34	This cell represents the total number of CMSP re-applications taken with a 2 month break that were received during the report month and were still pending at the end of the report month.
Cell 35	This Cell represents the arithmetic total of Cell 29, Cell 30, Cell 31, Cell 32, Cell 33 & Cell 34.
Cell 36	This cell represents the total number of CMSP re-applications taken with a 3 month break that were received during the report month and were approved during the report month.
Cell 37	This cell represents the total number of CMSP re-applications taken with a 3 month break that were received during the report month and were denied during the report month due to excess income.
Cell 38	This cell represents the total number of CMSP re-applications taken with a 3 month break that were received during the report month and were denied during the report month due to excess resources.
Cell 39	This cell represents the total number of CMSP re-applications taken with a 3 month break that were received during the report month and were denied during the report month due to other reasons.
Cell 40	This cell represents the total number of CMSP re-applications taken with a 3 month break that were received during the report month and were withdrawn during the report month.
Cell 41	This cell represents the total number of CMSP re-applications taken with a 3 month break that were received during the report month and were still pending at the end of the report month.
Cell 42	This Cell represents the arithmetic total of Cell 36, Cell 37, Cell 38, Cell 39, Cell 40 & Cell 41.
Cell 43	This cell represents the total number of CMSP re-applications taken with more than a 3 month break (but less than 1 year) that were received during the report

County Medical Services Program Form 237 Cell-by-Cell Description - Final

	month and were approved during the report month.
Cell 44	This cell represents the total number of CMSP re-applications taken with more than a 3 month break (but less than 1 year) that were received during the report month and were denied during the report month due to excess income.
Cell 45	This cell represents the total number of CMSP re-applications taken with more than a 3 month break (but less than 1 year) that were received during the report month and were denied during the report month due to excess resources.
Cell 46	This cell represents the total number of CMSP re-applications taken with more than a 3 month break (but less than 1 year) that were received during the report month and were denied during the report month due to other reasons.
Cell 47	This cell represents the total number of CMSP re-applications taken with more than a 3 month break (but less than 1 year) that were received during the report month and were withdrawn during the report month.
Cell 48	This cell represents the total number of CMSP re-applications taken with more than a 3 month break (but less than 1 year) that were received during the report month and were still pending at the end of the report month.
Cell 49	This Cell represents the arithmetic total of Cell 43, Cell 44, Cell 45, Cell 46 , Cell 47 & Cell 48.
Cell 50	This Cell represents the arithmetic total of Cell 7, Cell 14, Cell 21
Cell 51	This Cell represents the arithmetic total of Cell 53 , Cell 54 & Cell 58
Cell 52	This Cell represents the arithmetic total of Cell 1, Cell 8, Cell 15
Cell 53	This Cell represents the arithmetic total of Cell 52
Cell 54	This Cell represents the arithmetic total of Cell 55, Cell 56, Cell 57
Cell 55	This Cell represents the arithmetic total of Cell 2, Cell 9, Cell 16
Cell 56	This Cell represents the arithmetic total of Cell 3, Cell 10, Cell 17
Cell 57	This Cell represents the arithmetic total of Cell 4, Cell 11, Cell 18
Cell 58	This Cell represents the arithmetic total of Cell 5, Cell 12, Cell 19
Cell 59	This Cell represents the arithmetic total of Cell 6, Cell 13, Cell 20
Cell 60	This Cell represents the arithmetic total of Cell 59
Cell 61	This cell represents the total number of CMSP individuals with an aid code of 8F who had a re-certification completed in the report month.
Cell 62	This Cell represents the arithmetic total of cell 51 + Cell 61
Cell 63	This Cell represents the total number of individuals on hand in the beginning of the month. This number must agree with the number in Cell 77 on last month's facsimile.
Cell 64	This Cell represents the arithmetic total of Cell 65 & Cell 66
Cell 65	This Cell represents the arithmetic total of Cell 52
Cell 66	This Cell represents the total number of individuals that were approved for reasons other than new applications or re-applications (e.g. rescinds).
Cell 67	This Cell represents the arithmetic total of Cell 63 & Cell 64
Cell 68	This Cell represents the arithmetic total of Cell 69, Cell 70, Cell 74, Cell 75 & Cell 76
Cell 69	This Cell represents the total number of individuals that were discontinued from CMSP due to end of Certification period.
Cell 70	This Cell represents the arithmetic total of Cell 71, Cell 72, Cell 73
Cell 71	This Cell represents the total number of individuals that were discontinued from CMSP due to being found eligible for Medi-Cal (SSI Eligible)
Cell 72	This Cell represents the total number of individuals that were discontinued from CMSP due to being found eligible for Medi-Cal (DAPD Eligible)
Cell 73	This Cell represents the total number of individuals that were discontinued from

County Medical Services Program Form 237 Cell-by-Cell Description - Final

	CMSP due to being found eligible for Medi-Cal Other reasons (not stated in cells 71 & 72))
Cell 74	This Cell represents the total number of individuals that were discontinued from CMSP due to client request due to reapplication with budget change
Cell 75	This Cell represents the total number of individuals that were discontinued from CMSP due to client request for reasons other than budget change
Cell 76	This Cell represents the total number of individuals that were discontinued from CMSP due to reasons not stated in Cell 69, Cell 70, Cell 74 and Cell 75.
Cell 77	This Cell represents the arithmetic total of Cell 68 subtracted from Cell 67.

**COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
DENIAL/DISCONTINUANCE
OF BENEFITS**

(COUNTY STAMP)

Case number: _____

District: _____

Denial/discontinuance for: _____

(Names)

We have reviewed all information available to us about your circumstances, and we find that:

- ☐ Your application for CMSP dated _____ has been denied.
(Month) (Day) (Year)
- ☐ Your eligibility to receive CMSP will be discontinued effective the last day of _____.
(Month)

The reason for this denial/discontinuance is:

Do not throw your plastic ID card away. You can use it again if you become eligible for CMSP or Medi-Cal. The authority that requires this action is in CMSP All County Letter No. 04-07 and/or appropriate CMSP Eligibility Manual sections.

If you have any questions about this action, or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us and that you may reapply at any time.

Eligibility Worker_____
Phone_____
Date

**APPLICANT COPY
CASE COPY**

**PROGRAMA DE SERVICIOS
MÉDICOS DEL CONDADO
AVISO DE ACCIÓN
NEGACIÓN/DESCONTINUACIÓN DE LOS BENEFICIOS**

(COUNTY STAMP)

Número del caso: _____

Distrito: _____

Negación/descontinuación para: _____

(Nombres)

Hemos revisado toda la información de que disponemos tocante a su situación y hallamos que:

☐ Su aplicación para CMSP fechada el _____ ha sido negada.
(Día) (Mes) (Año)

☐ Su elegibilidad para recibir CMSP ha sido descontinuada a partir del último día del mes de _____.

Esta negación/descontinuación se hace porque:

No tire su tarjeta de identificación de CMSP. Usted puede utilizarla otra vez si usted es elegible de nuevo para CMSP o Medi-Cal. La autoridad que requiere esta acción esta en la carta "CMSP All County Letter No. 04-07" o en las secciones apropiadas del Manual de la Elegibilidad de CMSP.

Si Ud. tiene alguna pregunta acerca de esta acción o alguna información adicional pertinente a su situación que no nos haya reportado, haga el favor de escribirnos o llamarnos por teléfono. Responderemos a sus preguntas o haremos una cita para verle personalmente. Recuerde que esta acción solamente tiene que ver con la información que Ud. nos reportó y que Ud. puede volver a hacer una aplicación cuando quiera.

Trabajador de Elegibilidad

Teléfono

Fecha

**COPIA DEL SOLICITANTE
COPIA DEL CASO**

COUNTY MEDICAL SERVICES PROGRAM NOTICE OF ACTION APPROVAL/DENIAL OF BENEFITS

(County Stamp)

Case name: _____
 Case number: _____
 District: _____
 This affects: _____
 (Names)

Your application for CMSP benefits has been approved. Your CMSP certification period begins the first day of (month/year) _____ and ends last day of (month/year) _____. You will be eligible as follows:

Month:	_____	_____	_____ through _____
Gross income:	\$ _____	\$ _____	\$ _____
Net nonexempt income:	\$ _____	\$ _____	\$ _____
200% FPL*:	\$ _____	\$ _____	\$ _____
Eligible for the month:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance need:	\$ _____	\$ _____	\$ _____
Excess income/monthly share-of-cost:	\$ _____	\$ _____	\$ _____

* If this information indicates you are not eligible for a particular month, it was because your Net Nonexempt Income exceeded 200% of the Federal Poverty Level (FPL).

For the months that the above indicates you are eligible, you will receive your plastic Benefits Identification Card (BIC) soon. Do not throw this card away. This card is good as long as you are eligible for CMSP. Take this plastic card to your pharmacy, doctor, or other Medi-Cal/CMSP provider when you request health care services. Your BIC will show your provider *if* you have a share-of-cost to pay. The amount that you pay or obligate to the health care providers will be automatically computed. After your total monthly share-of-cost has been paid or obligated, you will not have to pay for covered health care services received that month from Medi-Cal/CMSP providers.

In addition to the plastic BIC as described above, you will soon receive a pharmacy benefits card from MediImpact. You should present this card along with the BIC to your pharmacy when obtaining medications and other pharmacy services.

CMSP eligibility is limited to individuals aged 21 through 64 years.

CMSP now limits the length of your eligibility. You will automatically be discontinued from CMSP at the end of the month stated above. If you continue to need aid after the date of discontinuance, you can reapply during your last month of eligibility. Please do not reapply sooner.

Eligibility Worker	Telephone number	Date

Do not throw your plastic ID card away. You can use it again if you become eligible for CMSP or Medi-Cal. The authority that requires this action is in CMSP All County Letter No. 04-07 and/or appropriate CMSP Eligibility Manual sections.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE.

**COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
APPROVAL/DENIAL OF BENEFITS RESTRICTED TO
EMERGENCY MEDICAL SERVICES**

(County Stamp)

Case name: _____
Case number: _____
District: _____
This affects: _____
(Names)

Your application for CMSP benefits has been approved. Your CMSP certification period begins the first day of (month/year) _____ and ends the last day of (month/year) _____. You will be eligible as follows:

Month:	_____	_____
Gross income:	\$ _____	\$ _____
Net nonexempt income:	\$ _____	\$ _____
200% FPL*:	\$ _____	\$ _____
Eligible for the month:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance need:	\$ _____	\$ _____
Excess income/monthly share-of-cost:	\$ _____	\$ _____

* If this information indicates you are not eligible for a particular month, it was because your Net Nonexempt Income exceeded 200% of the Federal Poverty Level (FPL).

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction to any bodily organ or part. The emergency must be certified by a physician or other appropriate medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Health Services may review the provider's decision that an emergency service was required.

Your application for full CMSP benefits is denied. We have granted you, instead, eligibility for emergency medical treatment.

We are taking this action because you are a noncitizen who (one of the following reasons applies):

- Does not have satisfactory immigration status according to information received from the Immigration and Naturalization Service (INS).
- Lacks documentary proof of satisfactory immigration status for CMSP purposes.
- Has been admitted to the United States as a nonimmigrant for a limited period of time.

For the months that the above indicates you are eligible, you will receive your plastic Benefits Identification Card (BIC) soon. Do not throw this card away. This card is good as long as you are eligible for CMSP. Take this plastic card to your pharmacy, doctor, or other Medi-Cal/CMSP provider when you request health care services. Your BIC will show your provider if you have a share-of-cost to pay. The amount that you pay or obligate to the health care provider(s) will be automatically computed. After your total monthly share-of-cost has been paid or obligated, you will not have to pay for covered health care services received that month from Medi-Cal/CMSP providers.

In addition to the plastic BIC as described above, you will soon receive a pharmacy benefits card from Medi-Cal. You should present this card along with the BIC to your pharmacy when obtaining medications and other pharmacy services.

CMSP now limits the length of your eligibility. You will automatically be discontinued from CMSP at the end of the month stated above. If you continue to need aid after the date of discontinuance, you can reapply during your last month of eligibility. Please do not reapply sooner.

Eligibility Worker

Telephone number

Date

Do not throw your plastic ID card away. You can use it again if you become eligible for CMSP or Medi-Cal. The authority that requires this action is in CMSP All County Letter No. 04-07 and/or appropriate CMSP Eligibility Manual sections.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE.